N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1939 FEB 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 1671

Registered No. 69

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH
County: Buchanan
Township: Washington
City: St Joseph, Mo (No. State Hospital #2 St. Ward)

2. FULL NAME: Cordelia Kincaid Saxton

(a) Residence, No. Kansas City, Mo St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Roy R. Saxton

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 10, 1902

7. AGE: Years 36 | Months 10 | Days 12 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

FATHER
13. NAME: Robert Kincaid
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

MOTHER
15. MAIDEN NAME: Olive Thompson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Oklahoma

17. INFORMANT (ADDRESS): Records of Hosp. #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE: State Hosp #2 DATE: Jan. 25, 1939

19. UNDERTAKER (ADDRESS): Stanley Funeral Home, St Joseph, Mo

20. FILED: Jan 25, 1939 H. J. Nestlebush, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Jan. 22, 1939

22. I HEREBY CERTIFY That I attended deceased from Jan. 11, 1939 to Jan. 22, 1939
I last saw her alive on Jan. 22, 1939 Death is said to have occurred on the date stated above, at 2:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	
~~Acute Myocardial Failure~~	1939
Other contributory causes of importance:	
General Paralysis of Insane	1934

Name of operation: none Date of:
What test confirmed diagnosis? Path. Clin. Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury ....., 19....
Where did injury occur? None (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury: None
Nature of injury:

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify:
(Signed) A. E. Miller M.D. M. D.
(Address) State Hospital #2, St Joseph, Mo

STATEMENT BY LICENSED EMBALMER

I, John Ray Blaney, Licensed Embalmer No. 2435 hereby certify that the body recorded on the reverse side of this Certificate was embalmed by _____

or by _____, Registered Apprentice No. _____

(Signed) John Ray Blaney

Licensed Embalmer No. 2435

NOTE: *The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.*
(Failure to comply with the above regulation constitutes grounds for revocation of license.)